| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155586 | | (X2) MULTIPLE CO A. BUILDING B. WING | ONSTRUCTION 00 | (X3) DATE SURVEY COMPLETED 05/03/2012 | |
|---|---|--|---------------------|--|----------------------|
| | PROVIDER OR SUPPLIE | | STREET . 9802 C | ADDRESS, CITY, STATE, ZIP CODE OLDWATER ROAD WAYNE, IN 46825 | |
| (X4) ID PREFIX TAG | (EACH DEFICIE) | STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | (X5) COMPLETION DATE |
| F0000 | Complaints IN0 IN00107486. Complaint IN00 Federal/state de allegations are complaint IN00 due to lack of events. | 2107444 - Substantiated. ficiencies related to the fitted at F502, F505, F514. 2107486 - Unsubstantiated vidence. April 30, and May 1, 2, 3, 1: 000283 r: 155586 00275020 I-TC r, RN | F0000 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/01/2012 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED | | | | | |
|--|----------------------------------|--------------------------------|--|---|------------|--|--|--|
| AND PLAN | OF CURRECTION | 155586 | A. BUILDING | 00 | 05/03/2012 | | | |
| | | 100000 | B. WING | ADDRESS CITY STATE OF CORE | 30/00/2012 | | | |
| NAME OF F | PROVIDER OR SUPPLIE | R | | ADDRESS, CITY, STATE, ZIP CODE | | | | |
| LUTHER | AN LIFE VILLAGES | 3 | | 9802 COLDWATER ROAD FORT WAYNE, IN 46825 | | | | |
| (X4) ID | SUMMARY S | STATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTION | (X5) | | | |
| PREFIX | | NCY MUST BE PERCEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | COMPLETION | | | |
| TAG | REGULATORY OF | R LSC IDENTIFYING INFORMATION) | TAG | DEFICIENCY) | DATE | | | |
| | Sample: 8 | | | | | | | |
| | These deficienci | es reflect state findings | | | | | | |
| | | nce with 410 IAC 16.2. | | | | | | |
| | | | | | | | | |
| | Quality review 5 Williams, RN | 5/10/12 by Suzanne | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
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FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WNG411

Facility ID: 000283

If continuation sheet Page 2 of 14

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | (X2) MULTIPLE CONSTRUCTION A. BUILDING 00 | | | SURVEY ETED | |
|--|----------------------|---|---|------------|--|-----------------|--------------------|
| | | 155586 | | | | 05/03/ | |
| | | | B. WIN | | ADDRESS, CITY, STATE, ZIP CODE | 1 | • |
| NAME OF F | PROVIDER OR SUPPLIER | C. | | 1 | OLDWATER ROAD | | |
| LUTHER | AN LIFE VILLAGES | 3 | | | WAYNE, IN 46825 | | |
| | | | | | 1 | | |
| (X4) ID PREFIX | | TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL | ID PREFIX | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | | (X5) COMPLETION |
| TAG | ` | LSC IDENTIFYING INFORMATION) | | TAG | CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | DATE |
| F0502 | 483.75(j)(1) | ESC IDENTIFICATION | | 1710 | | | DATE |
| SS=D | | AIN LABORATORY | | | | | |
| | SVC-QUALITY/1 | ΓΙΜΕLΥ | | | | | |
| | | provide or obtain laboratory | | | | | |
| | | the needs of its residents. | | | | | |
| | timeliness of the | sponsible for the quality and | | | | | |
| | | ation, interviews and | F05 | 02 | 1. What measures were take | n | 06/02/2012 |
| | | ne facility failed to ensure | | ~ - | for residents directly affected | | 0,02,2012 |
| | | was obtained within the | | | Resident #D received | | |
| | _ | red. This deficiency | | | appropriate antibiotic therapy | | |
| | affected 1 of 3 re | <u>J</u> | | | based on culture results of 05-02-2012. 2. What measu | roc | |
| | | | | | were put in place to identify | 162 | |
| | 1 | were reviewed, in a | | | other residents at risk? All | | |
| | sample of 8. (Re | sident #D) | | | residents are at risk from this | | |
| | TO: 1: : 1 1 | | | | deficient practice. No similar | | |
| | Findings include | : | | | instances are noted to have | | |
| | 0 4/20/12 . 10 | | | | occurred since the survey date 3. What systemic change | 2 S. | |
| | | 0:45 a.m., during the | | | was put in place to ensure th | e | |
| | | RN #10 indicated | | | deficient practice does not | | |
| | | been treated with Flagyl | | | recur? | | |
| | ` | Clostridium Difficille) | | | Policy on Physician Notifica | tion | |
| | | contact isolation. | | | was reviewed and revised as deemed appropriate. | | |
| | | s were observed hanging | | | deemed appropriate. | | |
| | on a door mount | ed rack. | | | ·The method for tracking lab | | |
| | | | | | orders was revised on 5/7/201 | 2 to | |
| | The clinical reco | ord of Resident #D was | | | improve the timeliness in | | |
| | reviewed on 5/1/ | 12 at 3:40 p.m. and | | | reporting and follow up. | | |
| | indicated the resi | ident was admitted to the | | | ·Facility process regarding | | |
| | facility on 4/9/12 | 2 with diagnoses which | | | delivery of lab results reviewed | d | |
| | included, but we | re not limited to, | | | and modified. Lab results | | |
| | duodenal ulcers | and PEG (Percutaneous | | | delivered directly to nursing ur instead of being placed in Nur | | |
| | Endoscopic Gast | trostomy) tube placement. | | | Practitioner's mailbox for next | 5 C | |
| | | , J, r | | | visit review. | | |
| | On 4/14/12, a lab | boratory report indicated | | | | | |
| | the resident teste | • • | | | ·Nursing Managers/Shift Supervisors/Nursing Office | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WNG411

Facility ID: 000283

If continuation sheet

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | | |
|--|---|------------------------------|----------------|--------|--|-----------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING 00 | | | COMPLETED | |
| | | 155586 | B. WIN | | | 05/03/ | 2012 |
| | | | b. Wilv | | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF P | ROVIDER OR SUPPLIER | 8 | | | OLDWATER ROAD | | |
| LUTHER | AN LIFE VILLAGES | 3 | | | VAYNE, IN 46825 | | |
| | | | _ | | 7,1112, 11, 10020 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | | (X5) |
| PREFIX | • | ICY MUST BE PERCEDED BY FULL | | PREFIX | CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) | ΓE | COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION) | + | TAG | | | DATE |
| | C-difficille. | | | | Coordinator were in-serviced of the updated process regarding | | |
| | | | | | lab notifications which include | | |
| | On 4/14/12, phys | sician orders indicated | | | delivery of labs received direct | | |
| | the resident was | to receive Flagyl 500 mg | | | to each of the nursing units | , | |
| | three times daily | for ten days and the stool | | | instead of being placed in the | | |
| | was to be rechec | ked 48 hours after the | | | Nurse Practitioner's mailbox fo | or | |
| | antibiotic was co | | | | review. | | |
| | WIII 10 10 11 11 11 10 10 10 10 10 10 10 10 | ,p. 10000. | | | ·Nursing staff that perform | | |
| | The April 2012 N | MAR (Medication | | | physician notification have bee | an a | |
| | • | ` | | | in-serviced on the revised police | | |
| | Administration Record) indicated he received the last dose of Flagyl on | | | | specifically related to notifying | • | |
| | | | | | physician in the event that | | |
| | 2/24/12 at 4:00 p | o.m. | | | obtaining a culture specimen is | | |
| | | | | | delayed as well as abnormal la | ab | |
| | The ADL (Activ | ities of Daily Living) | | | results received. | | |
| | Flowsheet indica | ated the resident had 2 | | | 4. How will the corrective action be monitored? The | | |
| | bowel movemen | ts, on the evening shift | | | Director of Nursing or designer | α . | |
| | | lid not have another | | | will audit lab results requiring | C | |
| | bowel movemen | | | | followup on a daily basis for 8 | | |
| | bower movemen | t until 4/30/12. | | | weeks and on a weekly basis | for | |
| | Thomas vivos ma da | over autotion tha remark | | | 12 weeks. A monthly report of | | |
| | | cumentation the repeat | | | findings will be submitted to th | | |
| | - | vas obtained 48 hours | | | Quality Assurance Committee, | • | |
| | | ic had been completed or | | | which meets monthly, for the duration of the audits prescribe | ad he | |
| | that the physician | n had been consulted | | | above. Should the committee | Ju | |
| | about the delay i | n obtaining the stool | | | feel that systemic compliance | is | |
| | specimen. | | | | not being achieved then audits | 3 | |
| | | | | | will continue, with possible | | |
| | On 5/1/12 at 7:32 | 2 a.m., nursing notes | | | additional corrective action, un | | |
| | indicated a stool specimen had been obtained at 4:00 a.m. (7 days after the completion of the antibiotic) On 5/1/12 at 8:10 a.m., nursing notes | | | | compliance has been achieved | J. | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | _ | | | | | |
| | | specimen was sent to the | | | | | |
| | laboratory. | | | | | | |
| | | | | | | | |

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Event ID: WNG411

Facility ID: 000283

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155586 | | | LDING | NSTRUCTION 00 | (X3) DATE COMPL 05/03 | ETED | |
|--|-----------------------------------|--|----------|---------------------|--|------|----------------------------|
| | PROVIDER OR SUPPLIER | | <u> </u> | STREET A | DDRESS, CITY, STATE, ZIP CODE DLDWATER ROAD VAYNE, IN 46825 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN REGULATORY OR | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | | (X5) COMPLETION DATE |
| | | nt #D was up all night I a stool specimen had | | | | | |
| | A laboratory repositive for C-di | dent's stool tested | | | | | |
| | missed getting a 4/26/12, and the | o a.m., the DON sing) indicated they stool specimen on resident did not have overnent until 4/30/12. | | | | | |
| | This Federal tag IN00107444. | relates to Complaint | | | | | |
| | 3.1-49(a) | | | | | | |
| | | | | | | | |
| | | | | | | | |
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| | | | | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WNG411

Facility ID: 000283

If continuation sheet

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| STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155586 | | X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 00 COMPLETED 05/03/2012 | | | ETED | | |
|--|---|---|---------|--------|--|----------------------------|------------|
| | | 155586 | B. WING | | | 05/03/ | 2012 |
| | ROVIDER OR SUPPLIER | | 9 | 802 CC | DDRESS, CITY, STATE, ZIP CODE DLDWATER ROAD /AYNE, IN 46825 | | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | I | D | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIEN | CY MUST BE PERCEDED BY FULL | PRI | EFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETION |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | Т | AG | DEFICIENCY) | | DATE |
| | 483.75(j)(2)(ii) PROMPTLY NO RESULTS The facility must physician of the Based on observer record reviews, t promptly notify the results of a correport. This defice residents, whose reviewed, in a safe safe safe safe safe safe safe sa | TIFY PHYSICIAN OF LAB promptly notify the attending findings. ation, interviews and the facility failed to the physician regarding alture and sensitivity beincy affected 1 of 3 laboratory reports were mple of 8. (Resident #B) : :00 a.m., during the RN #10 indicated currently in the hospital. It is were observed hanging ident B's room door. RN resident #B was admitted the VRE (Vancomycin coccus). rd of Resident #B was 20/12 at 2:30 p.m. and ident was admitted to the 12, with diagnoses which are not limited to, anoxic and a pseudoaneurysm onal wound. It transferred to the | | AG | 1. What measures were tak for residents directly affected No residents were directly affected by this practice. Resident #B was admitted to thospital on 04-19-2012 and has subsequently been discharged from the facility. 2. What measures were put in place to identify other residents at rise. All residents are at risk from the deficient practice. No similar instances are noted to have occurred since the survey date. 3. What systemic change was put in place to ensure the deficient practice does not recur? Policy on Physician Notificat was reviewed and revised as deemed appropriate. Nursing staff that perform physician notification have been in-serviced on the revised policy specifically related to physician notification of abnormal lab results. Facility process regarding delivery of lab results reviewed and modified. Lab results delivered directly to nursing urinstead of being placed in Nursing takes. | en d? he as d k? his es. s | |
| | Nursing notes, da | ated 3/29/12 at 11:45 | | | Practitioner's mailbox for next visit review. | | |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) M | ULTIPLE CO | ONSTRUCTION | (X3) DATE SURVEY | | |
|--|--|--------------------------------|------------------|-------------|---|------------|----------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A DITE | LDING | 00 | COMPLETED |) |
| | | 155586 | A. BUI B. WIN | LDING IG | | 05/03/2012 | 2 |
| | | ı | D. WIN | | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF F | PROVIDER OR SUPPLIE | R | | | OLDWATER ROAD | | |
| LUTHER | AN LIFE VILLAGES | 3 | | | WAYNE, IN 46825 | | |
| | | | | | 77771NE, IIV 40020 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | ` | ICY MUST BE PERCEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | MPLETION |
| TAG | | R LSC IDENTIFYING INFORMATION) | | TAG | , | | DATE |
| | | L (left) groin has a | | | ·Nursing Managers/Shift | | |
| | wound noted that | at has a hx (history) of | | | Supervisors/Nursing Office Coordinator were in-serviced | on l | |
| | VRE. There is no | o documentation that | | | the updated process regarding | | |
| | VRE is cleared; | therefore, contact | | | lab notifications which include | | |
| | • | ated and observed." | | | delivery of labs received direc | | |
| | 1 | | | | to each of the nursing units | | |
| | On $4/2/12$ and of | order was written for | | | instead of being placed in the | | |
| | | | | | Nurse Practitioner's mailbox for | or | |
| | "C&S (culture and sensitivity) wound." | | | | review. | | |
| | | | | | 4. How will the corrective action be monitored? The | | |
| | _ | eliminary culture report | | | Director of Nursing or designe | | |
| | for the wound in | dicated there was heavy | | | will audit lab results requiring | | |
| | growth and a ser | nsitivity report would | | | followup on a daily basis for 8 | | |
| | follow. | | | | weeks and on a weekly basis | for | |
| | | | | | 12 weeks. A monthly report of | of | |
| | On 4/6/12 the se | ensitivity report for the | | | findings will be submitted to the | | |
| | | rted and faxed to the | | | Quality Assurance Committee | , | |
| | _ | | | | which meets monthly, for the | | |
| | 1 | al culture sensitivity report | | | duration of the audits prescrib above. Should the committee | | |
| | | sident #B cultured | | | feel that systemic compliance | | |
| | positive for Kluv | | | | not being achieved then audits | | |
| | Escherichia Coli | , and Enterococcus | | | will continue, with possible | | |
| | Faecium VRE (V | Vancomycin Resistant | | | additional corrective action, ur | ntil | |
| | Enterococcus). | | | | compliance has been achieve | d. | |
| | ĺ | | | | | | |
| | There was no do | cumentation the | | | | | |
| | | otified regarding the final | | | | | |
| | 1 ^ * | atil 4/9/12 (3 days after it | | | | | |
| | | ` • | | | | | |
| | nad been receive | ed by the facility). | | | | | |
| | | | | | | | |
| | | oner note, dated 4/9/12, | | | | | |
| | indicated "woun | d C&S (Culture and | | | | | |
| | Sensitivity) retur | rned." | | | | | |
| | | | | | | | |
| | On 4/9/12, two i | ntravenous antibiotics | | | | | |
| | | treat the wound infection | | | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/01/2012 FORM APPROVED OMB NO. 0938-0391

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155586 | | (X2) MULTIPLE CON A. BUILDING B. WING | 00 | COMPLETED 05/03/2012 |
|---|---|---|---|----------------------|
| | PROVIDER OR SUPPLIER AN LIFE VILLAGES | 9802 COI | DRESS, CITY, STATE, ZIP CODE LDWATER ROAD AYNE, IN 46825 | • |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE COMPLETION |
| | The order indicated Resident #B was to receive Zosyn 3.37 every six hours for ten days and Linesolid 600 mg every 12 hours for ten days. | | | |
| | On 5/3/12 at 9:00 a.m., the DON (Director of Nursing) indicated the final wound culture and sensitivity report was placed in the Nurse Practitioner's box so it could be reviewed during her next visit. The DON indicated the report should have been called to the nurse practitioner when it was received on 4/6/12. The Policy and Procedure for Physician Notification, revised 3/2012, provided by the DON, was reviewed on 5/3/12 at 9:15 a.m., indicated the physician should be notified immediately for "Any panic lab value or labs with a specific physicians' order" This Federal tag relates to Complaint IN00107444. 3.1-49(f)(2) | | | |

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Event ID: WNG411

Facility ID: 000283

If continuation sheet

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY |
|---|--|
| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 00 | COMPLETED |
| 155586 A. BUILDING B. WING | 05/03/2012 |
| STREET ADDRESS, CITY, STATE, ZIP CODE | <u>. </u> |
| NAME OF PROVIDER OR SUPPLIER 9802 COLDWATER ROAD | |
| LUTHERAN LIFE VILLAGES FORT WAYNE, IN 46825 | |
| | |
| (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFLY (FACH DEFICIENCY MUST BE PERCEDED BY FULL PREFLY (EACH CORRECTIVE ACTION SHOULD BE | (X5) |
| CROSS-REFERENCED TO THE APPROPRIA | |
| The Alberta of the Betti Tiro in Oktainon) | DATE |
| F0514 | |
| RECORDS-COMPLETE/ACCURATE/ACCE | |
| SSIBLE | |
| The facility must maintain clinical records on | |
| each resident in accordance with accepted | |
| professional standards and practices that are | |
| complete; accurately documented; readily | |
| accessible; and systematically organized. | |
| The clinical record must contain sufficient | |
| information to identify the resident; a record | |
| of the resident's assessments; the plan of | |
| care and services provided; the results of any | |
| preadmission screening conducted by the | |
| State; and progress notes. | |
| Based on interview and record review, the F0514 1. What measures were take | |
| facility failed to document the removal of for residents directly affected | d? |
| an intravenous mid line catheter, the No residents were directly affected by this practice. Residents | dont |
| administration of intravenous medications #B was admitted to the hospital | |
| and wound treatments. This deficiency on 04-19-2012 and has | <u>-</u> |
| affected 1 of 2 residents reviewed, who subsequently been discharged | b |
| received intravenous medications and 1 of from the facility. 2. What | |
| 2 regidents, who received wound | |
| treatments, in a sample of 8. (Resident lidentify other residents at risk from the sample of 8.) | |
| | IIS |
| #B) deficient practice. No similar instances are noted to have | |
| occurred since the survey date | es. |
| Findings include: 3. What systemic change was | |
| put in place to ensure the | |
| 1. The clinical record of Resident #B was deficient practice does not | |
| reviewed on 4/30/12 at 2:30 p.m. and recur? | |
| indicated the resident was admitted to the Policy on Physician Orders was reviewed with no revision | |
| facility on 3/29/12, with diagnoses, which was reviewed with no revision indicated. | 3 |
| included but were not limited to, anoxic Policy on Peripheral Cathet | |
| | ter |
| brain syndrome. Removal was reviewed with no | |
| brain syndrome. Resident #B was transferred to the Nursing staff were in-service. | 0 |

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Event ID: WNG411 Facility ID: 000283 If continuation sheet Page 9 of 14

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) M | ULTIPLE CO | NSTRUCTION | (X3) DATE S | URVEY | |
|--|---------------------|---|------------|--------------|--|---------|--------------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | Δ RIII | LDING | 00 | COMPLE | ETED |
| | | 155586 | B. WIN | | | 05/03/2 | 2012 |
| | | | D. WII. | | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF I | PROVIDER OR SUPPLIE | R | | | OLDWATER ROAD | | |
| LUTHER | AN LIFE VILLAGES | S | | | VAYNE, IN 46825 | | |
| | | | 1 | | | | |
| (X4) ID PREFIX | | STATEMENT OF DEFICIENCIES | | ID PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | | (X5) COMPLETION |
| TAG | ` | NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION) | | TAG | CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | DATE |
| TAG | REGULATOR FOR | CLSC IDENTIFTING INFORMATION) | + | IAG | specifically related to the above | | DATE |
| | | | | | noted policies | E | |
| | | lated 3/29/12 at 11:45 | | | ·Nurse Managers were | | |
| | a.m., indicated " | L (left) groin has a | | | in-serviced on Exception Repo | ort I | |
| | wound noted that | at has a hx (history) of | | | review, an auditing process | | |
| | VRE. There is n | o documentation that | | | generated by the facility's EMI | ₹ | |
| | VRE is cleared: | therefore, contact | | | system which allows | | |
| | | ated and observed." | | | management staff to review | | |
| | productions mitt | and and observed. | | | documentation for EMAR and | | |
| | On 4/6/12 the a | | | | ETAR. 4. How will the corrective | | |
| | | ensitivity report for the | | | action be monitored? The | | |
| | _ | orted and faxed to the | | | Director of Nursing or designe | e | |
| | 1 | al culture sensitivity report | | | will audit all documentation on | | |
| | indicated the Re | sident #B cultured | | | daily basis through the use of | | |
| | positive for Kluv | vera Ascorbata, | | | Exception Reports for 8 weeks | s | |
| | Escherichia Coli | i, and Enterococcus | | | and on a weekly basis for 12 | | |
| | | Vancomycin Resistant | | | weeks. A monthly report of | | |
| | Enterococcus). | | | | findings will be submitted to th | | |
| | Enterococcus). | | | | Quality Assurance Committee which meets monthly, for the | , | |
| | 0 . 4/0/12 4 | Coden and a second that are a | | | duration of the audits prescribe | -d | |
| | · · | ntravenous antibiotics | | | above. Should the committee | | |
| | were ordered to | treat the wound infection. | | | feel that systemic compliance | is | |
| | | | | | not being achieved then audits | s | |
| | On 4/10/12 at 3: | 34 a.m. nursing notes | | | will continue, with possible | | |
| | indicated a midl | ine intravenous catheter | | | additional corrective action, ur | | |
| | was place in the | right inner arm. | | | compliance has been achieved | d. | |
| | | | | | | | |
| | On 4/13/12 at 1: | 50 p.m., clinical infusion | | | | | |
| | | ndicated a midline | | | | | |
| | | eter was placed in the left | | | | | |
| | | icici was piaccu ili tile lett | | | | | |
| | arm. | | | | | | |
| | | | | | | | |
| | | ocumentation why the | | | | | |
| | intravenous cath | eter in the right arm had | | | | | |
| | been removed. | | | | | | |
| | | | | | | | |
| | On 5/3/12 at 9:0 | 0 a.m., the DON | | | | | |

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) M | ULTIPLE CO | NSTRUCTION | (X3) DATE SURVEY | |
|--|-----------------------------------|------------------------------|-------------|------------|--|-----------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING | | | COMPLETED |
| | | 155586 | B. WIN | G | | 05/03/2012 |
| NAME OF E | PROVIDER OR SUPPLIER | | | STREET A | DDRESS, CITY, STATE, ZIP CODE | |
| NAME OF I | KOVIDEK OK SUITELEN | | | 9802 C | OLDWATER ROAD | |
| LUTHER | AN LIFE VILLAGES | 3 | | FORT V | VAYNE, IN 46825 | _ |
| (X4) ID | SUMMARY STATEMENT OF DEFICIENCIES | | | ID | PROVIDER'S PLAN OF CORRECTION | (X5) |
| PREFIX TAG | ` | CY MUST BE PERCEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) | COMPLETION DATE |
| TAG | | LSC IDENTIFYING INFORMATION) | | TAG | BEIGHACI | DATE |
| | ` | sing) indicated she | | | | |
| | | ntravenous catheter had | | | | |
| | _ | n pulled out during | | | | |
| | _ | 4/13/12 . The DON | | | | |
| | | ident had not been | | | | |
| | documented. | | | | | |
| | The policy for th | e Peripheral Catheter | | | | |
| | | d 8/15/08, provided by | | | | |
| | · · | viewed on 5/3/12 at 9:15 | | | | |
| | a.m., indicated; | | | | | |
| | | tation in the medical | | | | |
| | | but is not limited to: | | | | |
| | 15.1 Date and tir | | | | | |
| | 15.2 Reason for | | | | | |
| | | condition of catheter | | | | |
| | 15.4 Site assessn | | | | | |
| | 13.4 Site ussessii | ilont | | | | |
| | The April 2012 I | MAR (Medication | | | | |
| | Administration F | Record) indicated | | | | |
| | Resident #B was | to receive the antibiotics | | | | |
| | Zosyn 3.375 gran | ms per intravenous | | | | |
| | infusion every si | x hours and Zyvox 600 | | | | |
| | mgs per intraven | ous infusion every | | | | |
| | twelve hours. | | | | | |
| | The Zosyn was r | not initialed as given on | | | | |
| | 4/17/12 at 12:00 | a.m. and 6:00 a.m. The | | | | |
| | Zyvox was not in | nitialed as given on | | | | |
| | _ | a.m. and on 4/17/12 | | | | |
| | 12:00 a.m. | | | | | |
| | 0.5/2/12 | 0 4 503 | | | | |
| | On 5/3/12 at 9:00 | | | | | |
| | indicated she had | | | | | |
| | explanation rega | rding why the antibiotics | | | | |

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | | (X2) M | ULTIPLE CO | NSTRUCTION | (X3) DATE S | |
|--|-----------------------------------|--|--------|---------------|--|-------------|--------------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUI | LDING | 00 | COMPL | |
| | | 155586 | B. WIN | G | | 05/03/ | 2012 |
| NAME OF P | PROVIDER OR SUPPLIER | | | | DDRESS, CITY, STATE, ZIP CODE | | |
| | AAEE.\#\.AQE | | | | OLDWATER ROAD | | |
| LUTHER | AN LIFE VILLAGES | | | FORTV | VAYNE, IN 46825 | | |
| (X4) ID | SUMMARY STATEMENT OF DEFICIENCIES | | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX TAG | ` | CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | | PREFIX TAG | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) | ΓE | COMPLETION DATE |
| TAG | | , | | IAU | | | DATE |
| | | ialed as given on the notes on the 24 hour | | | | | |
| | | | | | | | |
| | medications had | tating the intravenous | | | | | |
| | | ere looking into the | | | | | |
| | factors related to | | | | | | |
| | | | | | | | |
| | inedication docu | mentation/report system. | | | | | |
| | The March and A | April 2012 TARs | | | | | |
| | (Treatment Adm | inistration Records) | | | | | |
| | indicated Reside | nt #B was to receive a | | | | | |
| | wet to dry dressi | ngs (using a | | | | | |
| | gentamycin/daki | n solution), to a wound | | | | | |
| | on the left groin, | twice daily, starting on | | | | | |
| | 3/29/12. | | | | | | |
| | The treatment wa | as not initialed as being | | | | | |
| | done on 12 occas | sions between 3/30/12 | | | | | |
| | through 4/16/12, | as follows: | | | | | |
| | 3/30/12, on the d | lay shift, | | | | | |
| | 3/31/12, on the e | vening shift, | | | | | |
| | 4/3/12, on the da | y shift, | | | | | |
| | 4/6/12, on the ev | ening shift, | | | | | |
| | 4/7/12, on the ev | ening shift, | | | | | |
| | 4/12/12, on the d | lay shift, | | | | | |
| | 4/12/12, on the e | vening shift, | | | | | |
| | 4/13/12, on the d | lay shift, | | | | | |
| | 4/13/12, on the e | vening shift, | | | | | |
| | 4/14/12, on the e | vening shift, | | | | | |
| | 4/15/12, on the e | vening shift., and | | | | | |
| | 4/16/12, on the d | lay shift. | | | | | |
| | On 5/3/12 at 9:00 | O a mothe DON | | | | | |
| | | d talked to the nursing | | | | | |
| | | t #B's unit. The DON | | | | | |
| | Juli on Resident | and dunic. The Don | | l | | | |

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| STATEMENT OF DEFICIENCIES | | X1) PROVIDER/SUPPLIER/CLIA | | | | | (X3) DATE SURVEY | | |
|---|--|----------------------------|--------|---|--|--------|-------------------------|--|--|
| AND PLAN OF CORRECTION | | IDENTIFICATION NUMBER: | | A. BUILDING 00 | | | COMPLETED 05/03/2012 | | |
| | | 155586 | B. WIN | | | 05/03/ | 2012 | | |
| NAME OF F | PROVIDER OR SUPPLIER | 8 | | | DDRESS, CITY, STATE, ZIP CODE | | | | |
| LLITUEDANI LIEE VII LACES | | | | 9802 COLDWATER ROAD FORT WAYNE, IN 46825 | | | | | |
| LUTHERAN LIFE VILLAGES | | | | <u> </u> | VATINE, IN 40025 | | | | |
| (X4) ID PREFIX | SUMMARY STATEMENT OF DEFICIENCIES | | | ID PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | | (X5) | | |
| TAG | (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | | TAG | CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | ΓE | COMPLETION DATE | | |
| 1710 | indicated the staff felt the treatments had | | | 1710 | | | DATE | | |
| | | | | | | | | | |
| | been done because the family requested | | | | | | | | |
| | the dressing changes be dated with a time. The DON indicated she had found | | | | | | | | |
| | documentation in the nursing notes | | | | | | | | |
| | indicating the treatment had been done on | | | | | | | | |
| | | | | | | | | | |
| | three of the twelve days (4/10/12, | | | | | | | | |
| | 4/15/12, and 4/16/12). | | | | | | | | |
| | Physician orders, dated 4/9/12, indicated | | | | | | | | |
| | RX Compound was to be applied on | | | | | | | | |
| | Resident #B's right buttocks every shift | | | | | | | | |
| | until the redness was healed. | | | | | | | | |
| | until the redicess | was neared. | | | | | | | |
| | On the April 2012 TAP the PY | | | | | | | | |
| | On the April 2012, TAR, the RX | | | | | | | | |
| | Compound treatment was not initialed as | | | | | | | | |
| | done on five occasions, between 4/10/12 | | | | | | | | |
| | and 4/18/12, as follows: the evening shift | | | | | | | | |
| | on 4/12, 13, 14/12 and the night shift on 4/16/12. | | | | | | | | |
| | 4/10/12. | | | | | | | | |
| | On 5/3/12 at 9:00 a.m., the DON | | | | | | | | |
| | indicated she was not able to find any | | | | | | | | |
| | documentation indicating the treatments | | | | | | | | |
| | were done. | | | | | | | | |
| | were done. | | | | | | | | |
| | The policy for Physician orders, dated | | | | | | | | |
| | 2/1/12, provided by the DON, reviewed | | | | | | | | |
| | , , | a.m., indicated "orders | | | | | | | |
| | | necked by the night shift | | | | | | | |
| | | insure they are on the | | | | | | | |
| | | re correctly written, etc | | | | | | | |
| | - | • | | | | | | | |
| and all corrections handled as able or reported to the oncoming shift for process | | | | | | | | | |
| | reported to the of | ncoming sinit for process | | | | | | | |

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/01/2012 FORM APPROVED OMB NO. 0938-0391

| | OF CORRECTION II | 1) PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER: 155586 | (X2) MULTIPLE CO A. BUILDING B. WING | 00 | COMPI 05/03 | | | | |
|--|------------------------------------|---|--|---|-------------|----------------------------|--|--|--|
| NAME OF PROVIDER OR SUPPLIER LUTHERAN LIFE VILLAGES | | | STREET ADDRESS, CITY, STATE, ZIP CODE 9802 COLDWATER ROAD FORT WAYNE, IN 46825 | | | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PERCEDED BY FULL CIDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY) | HOULD BE | (X5) COMPLETION DATE | | | |
| | completion" | | | | | | | | |
| | This Federal tag re IN00107444. | elates to Complaint | | | | | | | |
| | 3.1-50(a)(1) | | | | | | | | |
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